

**ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM**

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ___/___/___	3. Child's picture (optional)
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**Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER**

4. ASTHMA SEVERITY: <input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Exercise Induced <input type="checkbox"/> Peak Flow Best ___%	
5. ASTHMA TRIGGERS (check all that apply): <input type="checkbox"/> Colds <input type="checkbox"/> URI <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Pollen <input type="checkbox"/> Exercise <input type="checkbox"/> Animals <input type="checkbox"/> Dust <input type="checkbox"/> Smoke <input type="checkbox"/> Food <input type="checkbox"/> Weather <input type="checkbox"/> Other _____	
6. This authorization is NOT TO EXCEED 1 YEAR FROM ___/___/___ TO ___/___/___ FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216	7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer <input type="checkbox"/> Yes <input type="checkbox"/> No

**GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated**

The Child has <u>ALL</u> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can walk, exercise, & play <input type="checkbox"/> Can sleep all night If known, peak flow greater than _____ (80% personal best)					

**Exercise Zone  CALL 911  CALL PARENT  OTHER: \_\_\_\_\_**

The Child has <u>ANY</u> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Prior to all exercise/sports <input type="checkbox"/> When the child feels they need it					

**YELLOW ZONE - GETTING WORSE  CALL 911  CALL PARENT  OTHER: \_\_\_\_\_**

The Child has <u>ANY</u> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Some problems breathing <input type="checkbox"/> Wheezing, noisy breathing <input type="checkbox"/> Tight chest <input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other: _____ If known, peak flow between _____ and _____ (50% to 79% personal best)					

**RED ZONE - MEDICAL ALERT/DANGER  CALL 911  CALL PARENT  OTHER: \_\_\_\_\_**

The Child has <u>ANY</u> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Breathing hard and fast <input type="checkbox"/> Lips or fingernails are blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Medicine is not helping (15-20 mins?) <input type="checkbox"/> Other: _____ If known, peak flow below _____ (0% to 49% personal best)					

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CHILD'S NAME (First Middle Last)	DATE OF BIRTH (mm/dd/yyyy)
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**Section II. PRESCRIBER'S AUTHORIZATION – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER**

Place Stamp Here	
8. PRESCRIBER'S NAME/TITLE	TELEPHONE
ADDRESS	FAX
CITY	STATE
	ZIP CODE
9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)	
9b. DATE (mm/dd/yyyy)	

**Section III. PARENT/GUARDIAN AUTHORIZATION – MUST BE COMPLETED BY THE PARENT/GUARDIAN**

I authorize the childcare staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize childcare staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18; the childcare program may revoke the child's authorization to self-carry/self-administer medication.

**School Age Child Only: OK to Self-Carry/Self-Administer**  Yes  No

10a. PARENT/GUARDIAN SIGNATURE	10b. DATE (mm/dd/yyyy)
10d. CELL PHONE #	10e. HOME PHONE #
10f. WORK PHONE #	

Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency
Parent/Guardian 1		
Parent/Guardian 2		
Emergency 1		
Emergency 2		

**Section IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM**

1. Medication named above was received Expiration date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Medication labeled as required by COMAR <input type="checkbox"/> Yes <input type="checkbox"/> No 3. OCC 1214 Emergency Form updated <input type="checkbox"/> Yes <input type="checkbox"/> No 4. OCC 1215 Health Inventory updated <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Modified Diet/Exercise Plan <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A 6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A 7. Staff approved to administer medication is available onsite, field trips <input type="checkbox"/> Yes <input type="checkbox"/> No	Child Care Responsibilities: Reviewed by (printed name and signature): _____ DATE (mm/dd/yyyy) _____
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